

Health Reform Update

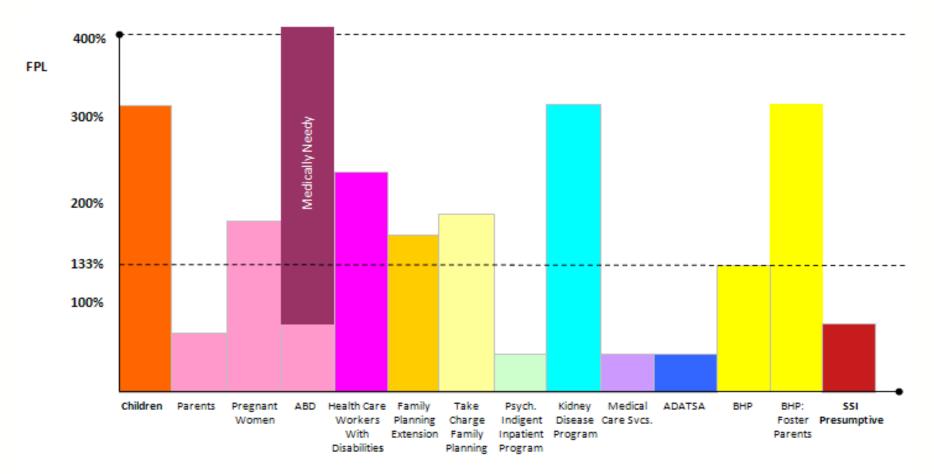
Transforming Care 2013

January 8, 2013

Nathan Johnson, Assistant Director, Health Care Policy

The ACA Opportunity

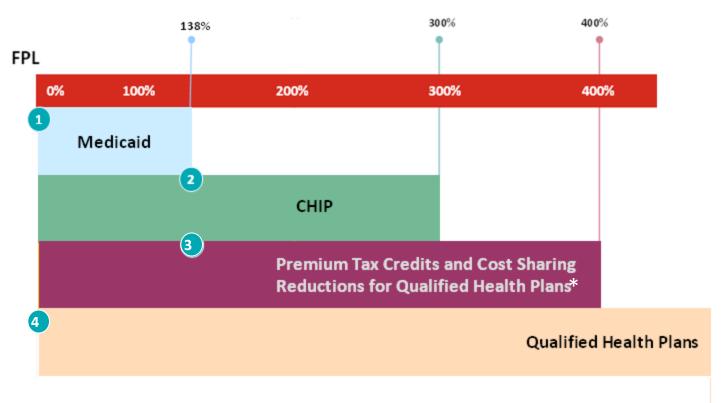
Today's Washington State Landscape



Coverage Program

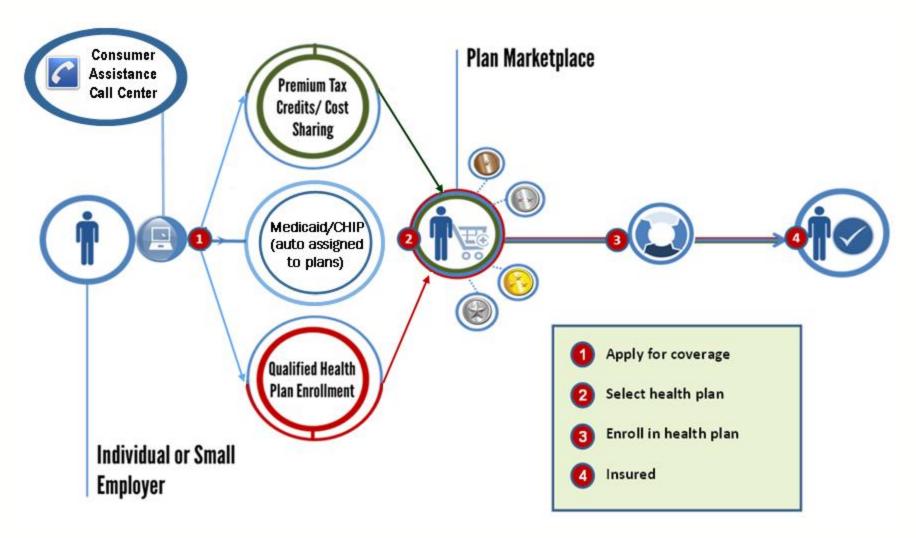


2014 ACA Continuum of "Insurance Affordability Programs"



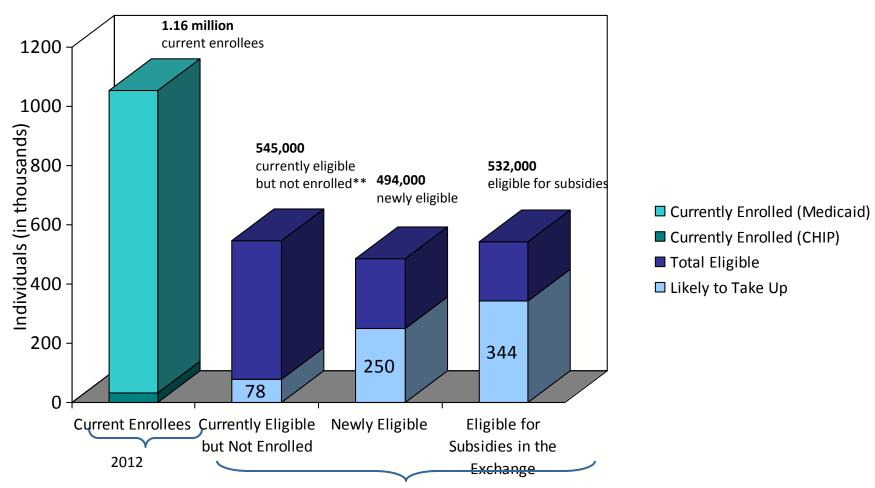
^{*} Federal Basic Health Plan Option for individuals with incomes between 138% and 200% of the FPL will not be available in 2014.

The Exchange: One-Stop Shopping for Health Insurance





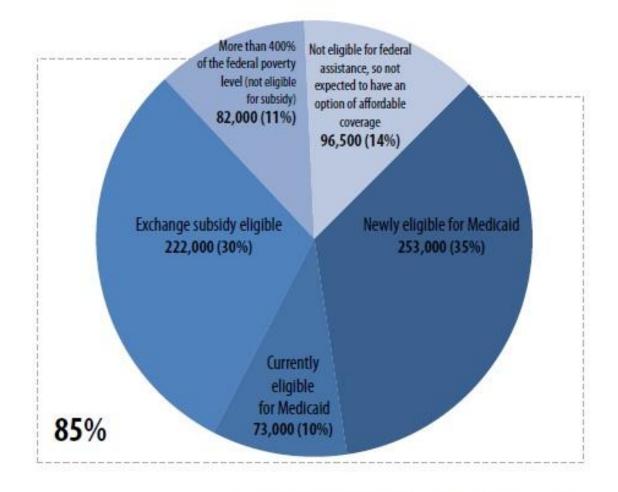
Post Implementation of the ACA: Subsidized Coverage Landscape in Washington



2014

Note: Analysis forecast assumes full take up rate and the ACA was in effect in 2011. **Includes individuals who have access to other contact to the ACA Medicaid Expansion in Washington, Health Policy Center, Urban Institute (May 2012); The ACA Basic Health Program in Washington State Health Care Authority for Medicaid/CHIP Washington State Health Care Authority enrollment.

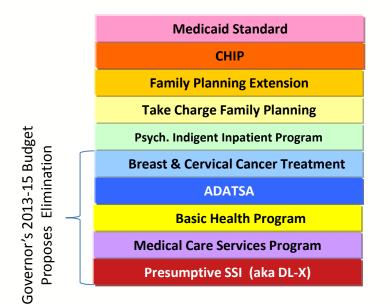
85% of Washington's uninsured adults will have access to affordable coverage under full implementation of the ACA



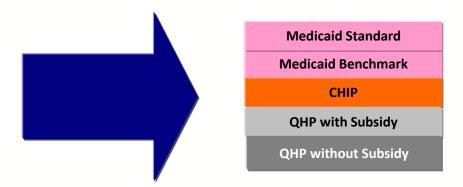
Medicaid Expansion Goals

- Optimize opportunities to streamline administrative processes
- Leverage new federal financing opportunities to ensure the Medicaid expansion is sustainable
- Maximize use of technology to create consumer-friendly application/enrollment/renewal experience
- Maximize continuity of coverage & care as individuals move between subsidized coverage options
- Reform the Washington way --- comply with, or seek waiver from, specific ACA requirements related to coverage and eligibility, as needs are identified

ACA Opportunity to Streamline Programs



2014 Coverage Continuum through Insurance Affordability Programs (IAP)



Streamlining considerations – numbers affected, access/continuity of coverage through IAP continuum, administrative complexity, transition timing



HealthPath Washington:

Our path toward health system transformation



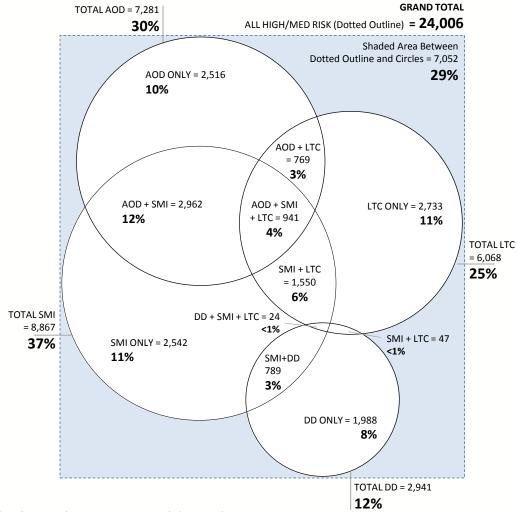
The Challenge

- Medicaid delivery system silos
 - Managed Care, FFS
 - County-based behavioral health
 - Dual-eligibles
 - Long-term Care
- Fragmented service delivery and lack of overall accountability
- Service needs and risk factors overlap in high-risk populations
- Incentives and reimbursement structures are not aligned to achieve outcomes
- Existing design is not sustainable



Service need and risk factor overlaps among high medical need Medicaid Only Disabled clients

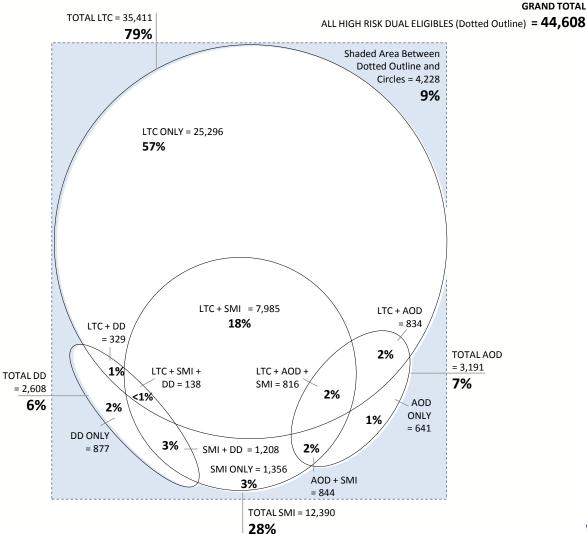
STATE FISCAL YEAR 2009





Service need and risk factor overlaps among high risk <u>DUAL ELIGIBLE</u> Aged or Disabled clients

STATE FISCAL YEAR 2009



Vision

- Organized systems of care with accountability for costs and outcomes
- Consumer-centric integration of medical, behavioral health and long-term care needs
- Preserve consumer choice and ensure access to qualified providers
- Reduce unnecessary utilization and duplication of services
- Align financial incentives for payers and providers
- Strike right balance between prescriptiveness and innovation

Strategy

- Embed robust delivery of health home services to bridge across all systems of care
- A new set of discrete services targeted to high cost/high risk clients who need intensive care coordination
- Focus on personal heath action goals for beneficiaries

Desired Outcomes

- Improve the ability of Medicaid consumers to function in their home and community
- Slow the progression of disease and disability
- Access the right care, at the right time and right place
- Successfully transition from hospital to other care settings with necessary follow-up care
- Reduce avoidable utilization and unnecessary costs

A Health Home Provides Integrated Care For:



HIGH COST | HIGH RISK POPULATIONS



CONDUCTS SCREENINGS FOR HEALTH RISKS AND REFERRAL NEEDS, EDUCATION AND COACHING, ASSISTS WITH TRANSITION CARE, PERSON-CENTERED HEALTH ACTION PLANNING, FACILITATES COMMUNICATION ACROSS SERVICE PROVIDERS.



SERVICE DELIVERY SYSTEMS

- Primary Care
- Montal Healt
- · Chemical Depended
- Hospital
- · Long-Term Care

HEALTH HOME COORDINATORS:

- Access the right care at the right time and place
- Improve ability to self-manage chronic conditions
- · Improve health outcomes
- · Reduce avoidable costs
- Community-based / Culturally appropriate
- Integrate care across medical, mental health, chemical dependency, and long term services and supports

← LEAD ENTITIES: ← ESSENTIAL MEDICAID

- Broad-based regional provider networks
- Contracted to the State as a Qualified Health Home
- Subcontract with local/regional organizations that provide all Health Home coordination services

PARTNERSENTITIES:

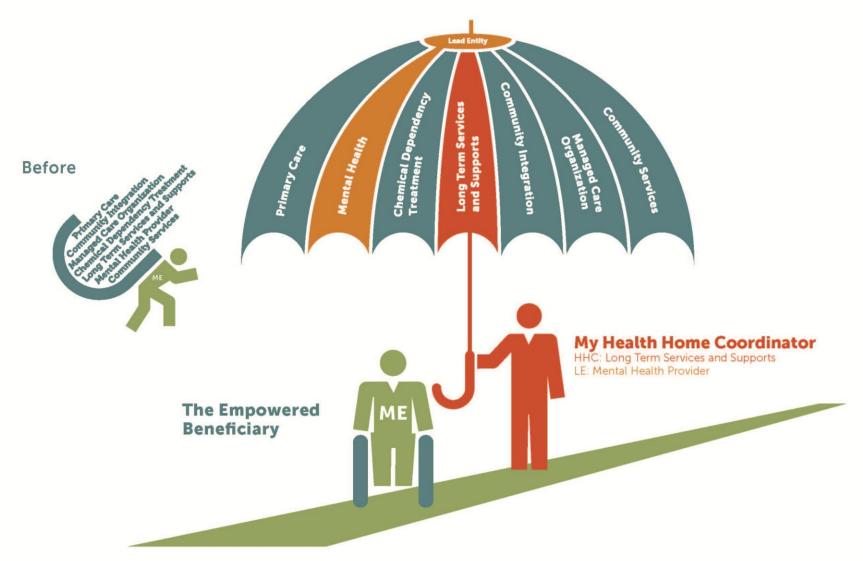
- Authorizing Entities
- Information Referral Services
- Assess and when appropriate, authorize Medicaid services

After Health Home

My Health Home Coordinator

Lead Entity

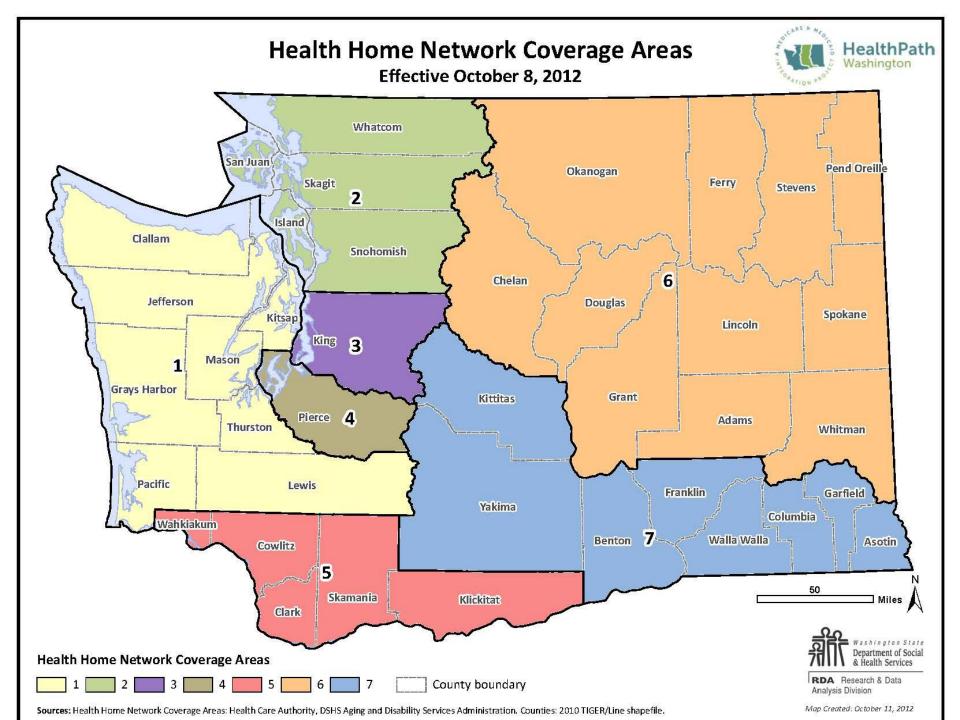




Coordination and Integration Create A Better Care Experience for the Beneficiary







Complementary Steps

- Joint Procurement
- Medicaid Expansion The new coverage continuum
- Integrated Care Pilots
- Multi-payer Medical Home Pilot
- Bree Collaborative
- Evidence-based purchasing initiatives
- CMMI Grant

More Information

- Main HCA web-site: http://www.hca.wa.gov/
 - For information about the Medicaid expansion:

http://www.hca.wa.gov/hcr/me

To contact us on the Medicaid expansion:

medicaidexpansion2014@hca.wa.gov

- Webinars & presentations around the state
 - See upcoming schedule & past events at:

http://www.hca.wa.gov/hcr/me/stakeholdering.html

- Listserv notification
 - To automatically receive information and stakeholdering notices subscribe at:

http://listserv.wa.gov/cgi-bin/wa?SUBED1=HCA-STAKEHOLDERS&A=1

